Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MEMORIAL THERAPEUTIC PRODUCTS
8200 WEDNESBURY LANE SUITE 475
HOUSTON TX 77074

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
CHUBB INDEMNITY CO

Carrier's Austin Representative Box
Box Number 17

MFDR Tracking Number
M4-10-2565-01

MFDR Date Received
January 19, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "LCD #5031 Revision"

Amount in Dispute: $269.76

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Payment was denied as the item had not yet been purchased, but was still being rented. Per DMERC LCD #L5031, 'Separate allowance will be made for replacement supplies when they are medically necessary and are used with a TENS unit that has been purchased and/or approved by Medicare…' The fact of the matter is that the item was not yet purchased and as such, supplies for the unit were not subject to payment until such time as the stimulator unit was purchased. Further, Section 110.3 of Chapter 15 of the Benefit Policy Manual states, 'Reimbursement may be made for replacement of essential accessores [sic] such as hoses, tubes, mouthpieces, etc., for necessary DME, only if the beneficiary owns or is purchasing the equipment.' It appears as though Dr. Griffith submitted a bill for the purchase of the stimulator unit, although an invalid modifier (NR) was used by Dr. Griffith on DS 9/30/09. As such, subsequent bills for monthly stimulator supplies should have been allowed. Memorial Therapeutic Products' bill for DOS 11/5/09 has been reevaluated and payment recommended…"

Response Submitted by: Chubb Indemnity, 2001 Bryan St., Ste. 3400, Dallas, TX 75201-3002

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 8, 2009 November 5, 2009	TENS Supplies	$269.76	$16.40

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 sets forth general provisions regarding dispute of medical bills.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
3. 28 Texas Administrative Code §133.308 sets out the procedures for requesting review by an Independent Review Organization (IRO).
4. 28 Texas Administrative Code §134.203 sets out the procedures for reimbursement of professional services.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 50 – Service not Deemed 'Medically Necessary' by payer.
   - B15 – Procedure/Services is not paid separately
   - Eff 8/1/03, there will be no separate allowance for replacement electrodes (A4556), conductive past (a4558), replacement btteries [sic] (A4630) or a battery charges used w/a purchased TENS/NMS unit.

Issues

1. Was the service/equipment provided to the injured worker medically necessary?
2. Was a payment made to the requestor after the request for medical fee dispute resolution was filed with the Division?
3. Is HCPCS Code A4630 reimbursable?
4. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §133.305(a)(4) defines a medical fee dispute as a dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) for health care determined to be medically necessary and appropriate for treatment of that employee's compensable injury. 28 Texas Administrative Code §133.305(b) requires that "If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021." 28 Texas Administrative Code §133.307(e)(3)(G) requires that if the request contains an unresolved adverse determination of medical necessity, the Division shall notify the parties of the review requirements pursuant to §133.308 of this subchapter (relating to MDR by Independent Review Organizations) and will dismiss the request in accordance with the process outlined in §133.305 of this subchapter (relating to MDR--General). The appropriate dispute process for unresolved issues of medical necessity requires the filing of a request for review by an Independent Review Organization (IRO) pursuant to 28 Texas Administrative Code §133.308 prior to requesting medical fee dispute resolution. Review of the submitted documentation finds that there are unresolved issues of medical necessity for the same service(s) for which there is a medical fee dispute. No documentation was submitted to support that the issue(s) of medical necessity have been resolved prior to the filing of the request for medical fee dispute resolution.

   The insurance carrier denied HCPCS Code A4595 for date of service September 8, 2009 using denial code 50 – "Service not deemed 'Medically Necessary' by payer" has not been resolved in accordance with 28 Texas Administrative Code §133.305(a)(4) and is not eligible for review.
2. Review of the respondents submission of an EOB and payment summary screen shows payment for HCPCS Code A4595 for date of service November 5, 2009 was made in accordance with 28 Texas Administrative Code §134.203 in the amount of $75.62. Therefore this HCPCS code will not be reviewed.
3. Per 28 Texas Administrative Code §134.203(d) The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows: (1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule." The requestor billed HCPCS Code A4630, defined as "replacement batteries, medically necessary, transcutaneous electrical stimulator, owned by patient", on September 8, 2009 and November 5, 2009. In accordance with 28 Texas Administrative Code §134.203(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1)Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules. According to LCD for Transcutaneous Electrical Service Stimulators (TENS) L5031 – "Separate allowance will be made for replacement supplies when they are medically necessary and are used with a TENS unit that has been purchased and/or approved by Medicare." For the date of service, September 8, 2009, there is no documentation to support that the TENS unit was purchased for the injured employee, therefore,

reimbursement for this date of service is not recommended. According to the respondent the TENS unit was purchased on or before date of service November 5, 2009. The respondent issued payment for the electrodes and denied payment for the replacement batteries using denial code B15 – 'Procedure/Services is not paid separately." No documentation was found to support the respondents' denial. Therefore, reimbursement is recommended:

- HCPCS Code A4630 - $6.56 x 125% = $8.20 x 2 units = $16.40

4. Review of the submitted documentation finds that reimbursement is due to the requestor.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $16.40.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $16.40 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		May 16, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.